

USAID/CAUCASUS/AZERBAIJAN

PRIMARY HEALTH CARE ASSESSMENT

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LIST OF ACRONYMS

ACQUIRE	Access, Quality and Use in Reproductive Health Activity
AIOC	Azerbaijan International Oil Consortium
AIHA	American International Health Alliance
AHAP	Azerbaijan Humanitarian Assistance Program
AMTSL	Active Management of Third Stage Labor
ARI	Acute Respiratory Infection
BCC	Behavior Change Communications
CDC	Center for Disease Control and Prevention
CDD	Control of Diarrheal Disease
CIP	Community Investment Program
CME	Continuing Medical Education
CPR	Contraceptive prevalence rate
DAC	Doctor ambulatory clinic
E&E	Europe and Eurasia
EPI	Expanded Program of Immunization
FAP	Feldsher /accusher punct = nurse/midwife health post
FSU	Former Soviet Union
GOAZ	Government of Azerbaijan
GTZ	German Technical Co-operation Agency
HIV+	Human Immune-deficiency Virus, Positive
IDP	Internally Displaced Person
IR	Intermediate Result
IMCI	Integrated Management for Childhood Illness
INGO	International Non-Governmental Organization
IUD	Intra Uterine Device
JICA	The Japanese International Cooperation Agency
MCH	Maternal and Child Health
MICS	Multiple Indicators Cluster Survey
MOH	Ministry of Health
MOF	Ministry of Finance
NCD	Non-Communicable Diseases
NRHO	National Reproductive Health Office
NGO	Non Governmental Organization
OB/GYN	Obstetrician / Gynecologist
ORS	Oral Rehydration Solution
PHC	Primary health care
PMTCT	Prevention of Mother to Child Transmission
PVO	Private Voluntary Organizations
RFA/RFP	Request for Applications / Requests for Proposals
RH	Reproductive Health
RH/FP	Reproductive Health/Family Planning
RHS	Reproductive Health Survey
SES	Sanitary Epidemiological Stations
STI	Sexually Transmitted Infection
TB/DOTS	Tuberculosis/Directly Observed Treatment – Short Course
UN	United Nations
USAID	United States Agency for International Development
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children’s Fund
UNFPA	United Nations Population Fund
VCT	Voluntary counseling and testing
WHO	World Health Organization
WB	World Bank

EXECUTIVE SUMMARY

The health status of Azeri citizens has declined dramatically since independence from the Soviet Union. Survey data indicate that the infant and under five mortality rates have increased to 81 and 92 per 1000 live births, respectively, the highest rates in the E&E region. The leading causes of death in children are acute lower respiratory infections (particularly pneumonia), diarrhea, and neonatal conditions. Malnutrition is widespread with a reported 13 percent of children stunted (low height for age) and 2.4 percent wasted (low weight for age). Anemia in women (40%) and children (32%) is substantial, the prevalence of iodine deficiency disorders is as high as 50-60%, and vitamin A deficiency was found in over 80 percent of children. Fertility is low, but only 12% of couples use modern family planning methods, and abortion remains the major fertility control method.

The health of adults has also suffered, and life expectancy has decreased. The leading causes of mortality among adults in Azerbaijan are cardiovascular diseases, cancers, diabetes, and injuries, and these are increasing. A significant portion of the non-communicable disease burden is related to sedentary life styles, obesity, and cigarette and alcohol consumption. According to the World Health Organization (WHO) 2003 World Development Report, life expectancy is 65.8 years, 63 for males and 68.6 for females. The nearly six year lower life expectancy for males indicates serious issues related to their lifestyles, their burden of non-communicable diseases, and poor quality of health care. These issues have an important impact on economic growth and the future productivity of the workforce, as well as on the increased burden of health care financing.

Like many other former Soviet republics, Azerbaijan retains much of the pre-independence health system structure and organization, but with greatly reduced funding and effectiveness of functioning. The highly centralized health care system is characterized by: hospital over-capacity, under-utilization and inefficiency; overemphasis on physician-based curative care at the expense of prevention and promotion; lack of integrated primary health care services; long hospital stays, ill equipped and supplied health centers, inadequately trained, poorly paid and motivated health professionals; and a seriously under-financed system riddled with corruption. Annual per capita public health expenditure is less than \$8 USD, and private—mostly out-of-pocket—expenditures for health care consume an ever-increasing proportion of household income.

The new USAID/Azerbaijan leadership is in the process of developing an updated country strategy for 2005-2009 (within the broader Caucasus strategy) and is taking a fresh look at each sector. With waiver of the Section 907 restrictions limiting cooperation with the Government of Azerbaijan (GOAZ), the Mission is changing from the humanitarian assistance mode of the past decade to a development assistance mode, for which updated strategic assessments are needed. In shifting to a development assistance mode, the Mission has also sought to open a broader dialogue with the GOAZ, to identify areas of cooperation and participation in the strategy development, and to build partnerships where feasible.

The health assessment describes the context within which further USAID initiatives will operate, outlines a number of important problems and potential areas of intervention in general, analyzes a number of specific gaps and issues identified over the course of the two week assessment, and provides a set of recommendations to the Mission. The major recommendations of the assessment are summarized below.

Recommendations: Increased Availability of Priority Primary Health Care Services

- Work at the policy level to better define primary health care in Azerbaijan to emphasize: integrated provision of basic services—especially outpatient services; expanded preventive services and health education/promotion; and upgrading technical and managerial skills of the midwives, feldshers and doctors who staff the peripheral village hospitals/clinics, and feldsher and midwifery posts (DACs and FAPs) who are the closest source of care in the community.
- Strengthen capacity of national and district level decision-makers to better utilize data for planning, decision making, and monitoring results.
- Dialogue with both the Ministry of Finance (MOF) and Ministry of Health (MOH) to support and encourage policy changes that allow for more rational budget allocations for health, and especially for primary health care.
- Undergraduate and Post-graduate training in family medicine and/or integrated primary health care (PHC) need to be strengthened and supported. Although there is a three-month post-graduate course in family medicine, the curriculum needs to be reviewed and upgraded. Additionally, Family Medicine, as a specialty, should be recognized by the MOH with development of a curriculum for the undergraduate level.
- USAID has organized an MOH Advisory Group, designed to open dialogue on key topics of mutual interest. It is important that this process continue, as it permits USAID to hear the priorities, concerns and directions of many of the departments within the MOH. It also creates a forum for idea exchange between USAID and many of the leaders within the MOH.
- Expand the availability of priority health services by improving provider capacity: strengthening antenatal care, skilled delivery, introducing best practices such as active management of third stage labor (AMTSL); basic practices for care of and protection of the newborn, and in recognizing, treating, and referring the most common childhood killers, diarrhea and acute respiratory infections.

Recommendations: People Better Informed about PHC Services, Healthy Lifestyles and Personal Responsibilities

- There is a need for a national approach to health education/promotion/behavior change. Currently there is no one department within the MOH responsible for health promotion. The Mission should consider providing technical support and advocate for creation of a health education/promotion/behavior change unit in the ministry.
- Community-based activities should support increased family participation in their own health care. This should include educating them on what services they should expect from PHC, as well as activities/messages on promotion of healthy lifestyles and prevention and early treatment of common illnesses.
- An education/communications/health promotion component will similarly be very important when the Mission develops plans for the content of the forthcoming health/PHC/reform component of its Five-Year Strategy. This technical component should address several aspects of communications/health promotion linked to building awareness and achieving behavior change. It should include communications approaches directed at the family and community level, but also should look at the possibility of national or sub-national public education campaigns.

- The health communications/promotion component of the new health support program will need to be closely coordinated with the ACQUIRE communications component. USAID should also seek the active participation of the MOH in planning communications activities.

Recommendations: Improved Quality of Primary Health Care Services

- Upgrade clinical skills of health care providers, especially related to primary health care, utilizing international standards and evidence-based protocols. This can also include retraining and/or cross-training PHC providers (doctors, feldshers, midwives and nurses) to offer basic services to all members of a family/community, including prenatal care, newborn care, family planning, immunizations, pediatric care, first aid, screening and referral, follow-up care & case management for chronic conditions (e.g., hypertension, diabetes, TB/DOTS), and patient education.
- Develop and strengthen the capacity for health services management. This would include using local data for local decision making, as well as training and technical assistance for management skills and supportive supervision to reinforce practical skills at the point of service delivery (competency-based).
- With additional training the role of mid-level providers (nurses, midwives and feldshers) should allow an expanded range of clinical services and patient education.

Recommendation: Top Down, Bottom Up Reform

It is clear that the proposed improvements and impact in the content and systems of delivering primary health care can only be achieved in a sustainable fashion with a wide range of significant changes in GOAZ policies, financial systems and allocation mechanisms, and other health reforms at the national level. These issues concern not only the MOH, but often involve the critical role of the Ministry of Finance, as well as the President's office.

Because of the critical importance of a wide range of policy reforms, health system changes, and financing reforms in the achievement and sustainability of the results, and given the Mission's expanding dialogue with the GOAZ, the team suggests that the Mission consider an **additional cross-cutting IR**:

Increased achievement of policy reform milestones that support and sustain health care and health status improvements.

Critical top down reforms include:

- Increasing the proportion of the national budget allocated to health, especially in light of the increasing revenues from petroleum development.
- Rational allocation of health budgetary resources away from the current dysfunctional system based on the number of hospital beds to one based on population and health needs. This shift is particularly important for strengthening primary health care, which is critical to making more cost-effective services available closer to the families and more accessible to poorer clients.

- To further reinforce the integration and improvement of primary health care will require improvement and institutionalization of the curriculum and training for family medicine physicians, building on the initiatives that have begun in a limited way.
- Changes in technical/programmatic policies related to who is authorized to provide services and drugs; and the general limitation of many services to hospitals and physicians that could be more efficiently shared and decentralized to non-medical providers, particularly at the peripheral health facilities outside of district or town areas.

Critical bottom-up reforms are:

- Improving the technical capacity of health providers at the community level, bringing the full range of basic primary health care services, including prevention and promotion, close to the families and communities. The attention of the MOH needs to be directed to the declining access to care of both urban and rural poor and people in remote areas.
- Draw on the wide range of successful experiences of the INGOs and other donors in building community involvement, knowledge and organization to better understand and take more responsibility for their own health needs, but also in stimulating advocacy and action to make health services more responsive and accessible. Look at the feasibility of more sustainable community health funds.
- Where possible, involve experienced NGOs in the process of identifying successful models of community involvement and actions that have potential for long term sustainability. The Mission should consider including NGO partners in its plan for implementing the Primary Health Care/Health Reform project.
- The health program should begin in selected districts which have a demonstrated interest and effective implementation experience in some of the ongoing PHC, RH and health reform programs, building on the successful experiences to demonstrate the potential to the MOH leadership.

HEALTH SECTOR ASSESSMENT

Introductory Note

The assessment team began its work with an initial briefing by the Baku Mission leadership to clarify the overall objective and scope of the assessment. In both the verbal guidance provided by the Country Coordinator and senior program officer, as well as in the written guidance provided by the contracts officer, several key principles and points were made.

The new Mission leadership is in the process of developing a new overall strategy for 2005-2009 (within the broader Georgia/Azerbaijan strategy). Since the Mission is shifting from the humanitarian assistance mode of the past decade to a development assistance mode, updated strategic assessments are needed. Several similar strategic assessments in other sectors were ongoing concurrently. The team was urged to look at the goals and program options in health in the most open fashion, and not necessarily be bound by the outline of the strategy document prepared early in 2004, which is considered general in nature. The Mission team will use the health assessment/program design report produced by the team as a key input into finalizing the Mission sector strategy. As a corollary to the strategic shift, the Country Coordinator made it clear that the focus of the program will no longer be primarily on humanitarian assistance in the IDP/refugee belt, and that the Azerbaijan Humanitarian Assistance Program (AHAP) which funded the important work of partner PVOs/NGOs will come to its natural conclusion. The assessment team was scheduled to meet with most of those partners and integrate the experiences and results of those groups. The Mission also indicated that the expected outcome of the health assessment was not a specific program design, but rather a series of concrete options that would be reviewed and built into a program design and procurement to be developed early in 2005.

With the shift to a development assistance mode, the Mission has begun to open a broader dialogue with the GOAZ, to seek areas of cooperation and participation in the strategy development, and to build partnerships where feasible. Recently, the Mission health staff organized the first meeting of a GOAZ health advisory group as an initial step in opening a collaborative dialogue with the Ministry of Health (MOH). The Mission leadership emphasized the importance of looking for mechanisms to broaden cooperation with the government, and the assessment team schedule included a variety of meetings with key individuals in the central MOH and the districts. The Country Coordinator, in both his comments to the team and in written guidance issued by him and the Mission contracts officer, emphasized their intent to make the procurement of program implementing agencies/mechanisms an open, competitive process to the greatest extent possible. As an initial step, the Mission will make the assessment team report available on the internet. This would provide equal access to any potentially interested party when the procurement process begins.

Purpose and Methodology of Health Sector Assessment

With a waiver of the Section 907 restrictions on working directly with the Azeri government, and in the context of growing health needs and development opportunities in a post-humanitarian setting, USAID/Azerbaijan requested a team to assess the current situation in primary health care to identify outstanding gaps and potential areas of program intervention. This team of six (which included two local consultant-facilitators) was tasked with providing:

1. A synthesis overview of the health sector in Azerbaijan,
2. Options for strategy and activities, and
3. Ideas and recommendations for future programmatic direction to enable the mission to refine a new five-year strategy.

Guiding the assessment team were several themes specified by the Mission:

1. What are the main areas of child and maternal health on which future programs should focus?
2. What are the selected primary health care issues that need to be included in the next five-year health program in addition to child and maternal health, given parameters outlined in the 2005-2009 strategy?
3. What are the “lessons learned” and “best practices” that should be built upon and carried forth into the future health programming, and how might this be done?

The team divided in two groups, to facilitate greater geographic coverage for field visits to partner sites and meetings with both public sector and non-government personnel. In depth discussions with stakeholders at all levels, including Azerbaijan Humanitarian Assistance Program (AHAP) partners, Ministry of Health personnel, private citizens, and medical professionals provided the basis for an understanding of the current physical and socio-political environment within which the Mission will be required to operate and make appropriate programming decisions. The assessment included a desk review and interviews in Washington D.C., along with data collection, in depth interviews, field visits, and team discussions in country.

Country Description and Context

Azerbaijan - a nation with a Turkic and majority-Muslim population - gained its independence after the breakup of the Soviet Union in 1991. Despite a 1994 cease-fire, Azerbaijan has yet to resolve its conflict with Armenia over the Nagorno-Karabakh enclave. Azerbaijan lost roughly 20% of its territory and now must support almost 900,000 refugees and internally displaced persons (IDP) as a result of the conflict. Population estimates range around 8 million, with 55% living in urban centers (with an estimated 600,000 to one million living/working abroad). Ethnic groups include Azeri (83%), Russian (6%), Armenian (6%), and 5% comprised of groups including Georgians, Avars, Tartars, Lezginians, and Talish.

Azerbaijan was the birthplace of oil production and oil remains the backbone of the economy. Economic growth over the last decade has been marked by only a modest impact on poverty reduction. GDP per capita has been falling each year since independence. Industrial output has declined by 69% since 1991, and agricultural production has declined by 47%. Over 50% of the population is poor, and poverty is found in all regions. Non-income indicators of poverty, including education levels, health care, and basic services appear to have deteriorated, particularly in rural areas. The current estimate of per capita public spending on health is \$7-8 dollars. Rural health care expenditures have dropped even more substantially. Less than 1% of GDP is spent on public sector health care services, as opposed to over 3% of GDP in the late 1980's. Although the GDP per capita is only \$742, much of the burden of health care costs increasingly falls upon the family, as a result of the decline in basic services and government funding.

The health status of Azeri citizens has worsened dramatically since independence. According to the 2001 USAID/CDC Reproductive Health Survey (RHS), the infant and under five mortality rates are 81 and 92 per 1000 live births, respectively. These figures are consistent with the UNICEF Multiple Indicator Cluster Survey (MICS). These rates are the highest in the E&E region, and are comparable to many countries in South Asia and sub-Saharan Africa. The leading causes of death in children are acute lower respiratory infections (particularly pneumonia), diarrhea, and neonatal conditions. According to the RHS, malnutrition is widespread, with a reported 13 percent of children stunted (low height for age) and 2.8 percent wasted (low weight for age). The prevalence of iodine deficiency disorders is high at 50 to 60 percent, and vitamin A deficiency was found in over 80 percent of children; 76 percent of the population has access to clean and safe drinking water. Although fertility is at or below replacement level (2.1), maternal mortality has increased to an estimated 79 (per 100,000 live births (UNICEF 2000). Azerbaijan has one of the highest abortion rates among the former Soviet republics (3.2 per woman).

As a result of the war with Armenia, there are about 900,000 refugees, including 650,000 internally displaced people (IDP) from Nagorno-Karabakh, and 250,000 refugees from Armenia – representing 11% of the population. Highly visible components of the population living in poverty are the internally displaced persons and refugees. Azerbaijan has one of the largest per capita displaced person burdens in the world, primarily resulting from this conflict. Slightly more than half, 54 percent, of IDPs live in urban areas and 46% are in rural areas. The majority of the IDPs have settled into main society, but many poor refugee settlements and camps still exist.

The leading causes of mortality among adults in Azerbaijan are cardiovascular diseases, cancers, diabetes, and injuries. A significant portion of the non-communicable disease burden is related to sedentary life styles, obesity, and cigarette and alcohol consumption. According to the WHO 2003 World Development Report, life expectancy is 65.8 years, 63 for males and 68.6 for females. The nearly six year lower life expectancy for males indicates serious issues related to men's lifestyles, their burden of non-communicable diseases, and poor quality of health care. These issues have an important impact on economic growth and the future productivity of the workforce. Among men, the incidence of cancer is highest for tracheal, bronchial, lung, and stomach cancers. Among women, the incidence is highest for breast, cervical, and uterine cancers.

The National Health Care System of Azerbaijan

Like other countries of the former Soviet Union (FSU), Azerbaijan inherited a centralized health care system that was focused on curative care, hospitals, and the role of specialized doctors. This health network is characterized by a highly centralized, hierarchical, administratively organized, top-down decision-making process. Under the Soviet model, health care was organized into a tiered system, with national level specialist hospitals and clinics, then to regional specialized hospitals and clinics, then district and city hospitals and polyclinics, and finally down to the rural ambulatory clinics (DACs = doctor ambulatory clinic) and its village health stations (FAPs = *feldsher accusher punct*=nurse/midwife health post). This very hierarchical system of health care utilizes vertical programs, each meant to address a specific health problem or segment of the population (e.g., women, children, etc.). Thus there are separate polyclinics, hospitals, staffs and administrations for cardiology, oncology, gynecology, pediatrics, infectious disease, TB, venereology (skin and STI), etc. These rural FAPs serve as the first (primary) level of care for rural residents. This expanded

system of hospitals and staffing has proven to be inefficient and largely underutilized, with less than 25% hospital occupancy. Ten years after independence, the health system structure remains largely unchanged.

While centralized tertiary hospitals are well maintained, and the semi-urban hospitals and polyclinics maintained to a lesser degree, the rural DACs and FAPs are often poorly equipped, not maintained, and lack basic supplies, leaving primary health care (PHC) services very limited or non-existent in these remote facilities. Patients who seek to utilize these services are most often referred to the outpatient polyclinics and hospitals in the larger centers or cities. As a result, patients often bypass the peripheral primary care level and go directly to the more specialized polyclinics and hospitals. Health education and promotion in communities is limited, with little emphasis on individual responsibility for health.

The health sector is often cited as one of the most corrupt sectors, and acceptance of “under-the-table” payments by patients to low-paid doctors and nurses is widely tolerated by the public. Other types of corruption include fraud in the procurement of pharmaceuticals, equipment and supplies; nepotism; and bribe-taking in staffing practices. Further, many patients voluntarily offer an additional gratuity when they feel satisfied with their health services, which complicates the distinction of additional fees. Health sector corruption impedes transition by reducing equitable access to health care, distorting efforts to more efficiently allocate health resources and eroding public confidence in the health system.

Health System Reforms

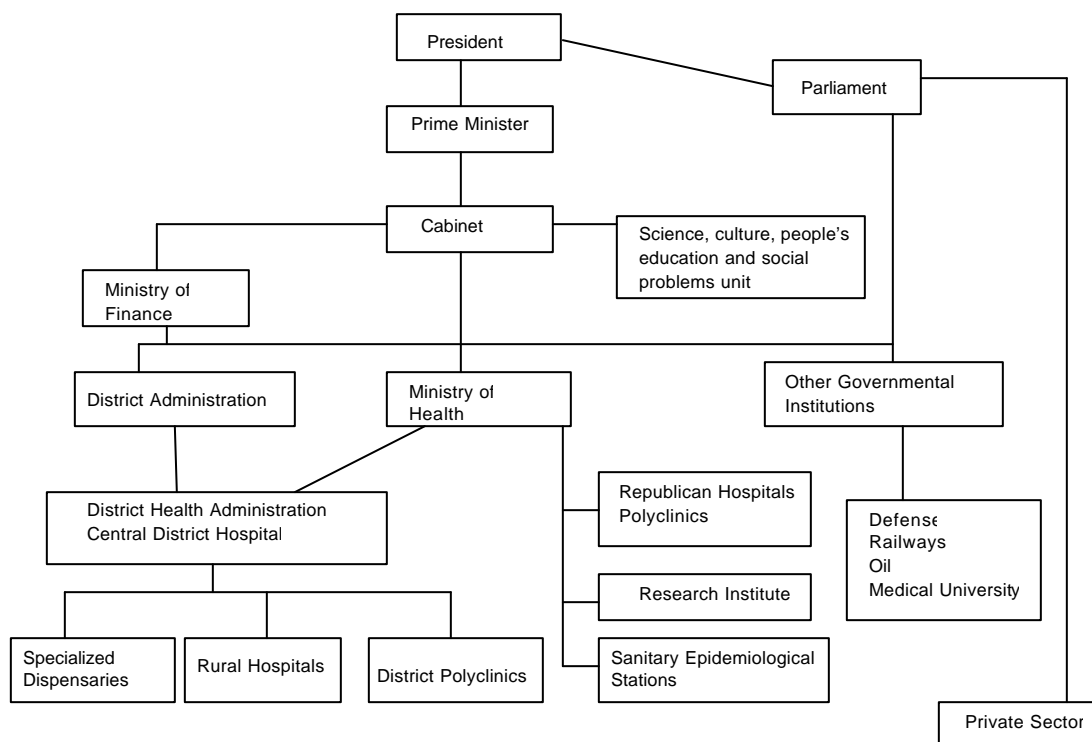
As many countries in the former Soviet Union have begun to undertake health reforms they have looked at the following issues: 1) the roles of state and market in health care; 2) movement from a very centralized system towards some decentralization, and perhaps even some privatization; 3) patient empowerment, rights and choice; 4) the evolving role of public health; 5) how to deal with resource scarcity; and 6) improving efficiency and quality service delivery dealing with issues of health care management, staffing and improving or developing human resources, restructuring hospitals, and renewing the role of primary health care (PHC). A number of Azerbaijan’s neighbors in both the Caucasus and Central Asia have begun significant health reform activities.

Although 15 laws have been passed on health reform, the MOH itself has been slow to build commitment to change, but is now working on a concrete strategic plan to address health priorities. A reduced health budget over recent years also has contributed to the decrease in health care capacity and quality of services. Per capita health expenditure is \$8.00, exactly the same level as Afghanistan, Burkina Faso, Central African Republic, and others. Out-of-pocket health expenditures of households are estimated to have increased by approximately 25 percent in 2002 from the previous year (World Bank 2002). Private health insurance is limited; a public insurance strategy is under development with World Bank (WB) technical support.

Azerbaijan has initiated some health reforms, most of which have been donor supported; but in general, the Soviet style health care system is still intact. There are a number of examples of health care reforms in Azerbaijan: UNFPA-funded formation of the National Reproductive Health Office, along with a network of 27 Reproductive Health/Family Planning Centers located throughout the country. UNICEF, under a World Bank loan, helped the GOAZ establish Primary Health Care

Centers in five districts aimed at improving maternal and child health (MCH) outpatient and hospital services, incorporating standard protocols based on best practices found elsewhere. Various international non-governmental organizations (INGOs) have also initiated primary health care reforms in selected communities and developed new approaches to community participation. In addition, the Government of Azerbaijan has laws that support other specific health reforms, including privatization of health care services and the creation of a national health insurance fund under the Social Security Agency.

Figure 1: Azerbaijan Health Care System Diagram:¹



KEY FINDINGS

Primary Health Care in the Azerbaijan Context

The meaning of primary health care in Azerbaijan is largely based on the Soviet model which is highly curative, heavily hospital-oriented and vertically segregates most of the primary care specialties, such as pediatrics, obstetrics/gynecology, internal medicine, etc., and which may often be located in separate settings rather than in single integrated settings. The vertical nature of health care is reinforced by medical education, with physicians trained in general medicine first (for 3 years) followed by speciality training for a subsequent 3-4 years of specialization.

¹ Health Care Systems in Transition, Azerbaijan, June 2004

During the field trip to the regions the USAID health assessment team visited Central District Hospitals (CHD), village hospitals, district polyclinics, doctor ambulatory clinics (DACs), feldsher/accusher points (FAPs), specialized dispensaries and women's consultation centers in 13 regions of Azerbaijan and interviewed health care managers, practitioners and clients. At visits to district and village facilities in a dozen districts, assessment team members noted a marked low occupancy level in virtually all of the hospitals visited—and other observers note national levels on the average below 20%. Given the continued rigid MOF allocation of funding based primarily on numbers of beds and staff, hospitals maintain bed capacity at levels far beyond demand and need, with resultant low occupancy levels. Likewise, primary care is often of low quality, continuity of care is undermined as patients are often seen by different doctors during successive visits. Quality of care is further weakened by poor laboratory services, with facilities often lacking diagnostic kits and functioning with outdated equipment, and suffering chronic shortages of drugs and supplies. Most of the hospitals visited by the assessment team had only intermittent electricity and water supply, many were in poor physical condition for lack of maintenance budgets, and very few had a heating system to make the conditions for patients more comfortable.

At the village level—especially in the poorest, most remote and mountainous regions, the basic primary care facilities are: district ambulatory centers (DACs), staffed by at least one physician, and feldsher/accusher points (FAPs), staffed by the male paramedic *feldshers* originated under the Soviet system, and mid-wives. In theory, the network of rural village level services is expected to address prenatal, delivery and post-partum care, immunizations and pediatric care, treatment of infectious disease (including TB drug treatment), and screening for the common chronic diseases. In reality, with the absence of doctors in many village facilities, midwives and feldshers have, of necessity, assumed broader responsibilities. For example, in many of the districts visited by the team, 50% or more of deliveries are at home—even higher in remote areas, and midwives attend the deliveries. In remote settings, access to the OB/GYN is limited. The midwife thus has to provide prenatal, delivery, and newborn care with minimal resources and without officially recognized authority.

On the other hand, because of the lack of appropriate providers or care in many villages, patients frequently choose to bypass this first level by going directly to hospitals or clinics in district towns. But for the poorest in the population, especially in rural areas, basic primary care services may not only be too distant, but may also be beyond their financial reach due to unofficial payments (there is no provision in MOH regulations for exempting charges for the poor). Many of the basic primary health services are designated as free by law, but because of the severe under-financing of the MOH health apparatus, a system of formal and informal payments has emerged to generate more revenues for MOH facilities and to informally supplement the income of the underpaid health providers. This, in turn, has greatly increased out-of-pocket costs to patients, especially when a health problem normally requires multiple provider contacts in a non-integrated system, further increasing barriers to service access.

District health officials explained that it is difficult to attract doctors to work in rural village hospitals because of the low pay (doctors receive official monthly salaries in the \$25 - \$35 range, well below average national wage), isolation, lack of adequate facilities, and better opportunities in the towns. The majority of the medical providers did not receive any post-service professional training and therefore are not abreast of recent technical developments in the medical field. There is little incentive for young medical professionals to return to and establish medical practice in their

home villages. District Chief Doctors reported a shortage of pediatricians and OB/GYNs in the rural areas.

Maternal Health

Azerbaijan has experienced a five-fold increase in maternal mortality since 1991 (USAID/CDC RHS, 2001). Maternal mortality rates also vary greatly due to poor and inconsistent reporting. The most recent UNICEF Survey estimated the maternal mortality at 79 per 100,000 live births (MICS 2000). The leading cause of maternal mortality is hemorrhage, complicated by a growing percentage of births at home not managed by a skilled attendant. Poor birth outcomes are widespread – on average, 21 per 1000 reported births were stillbirths (in part related to the continued use of the non-WHO definition of stillbirth). Clearly, maternal health services need a targeted focus, particularly in areas such as third stage management of delivery, obstetric emergencies, and emergency transport schemes.

According to the RHS, the total induced abortion rate is 3.2 per woman, one of the highest in Eastern Europe and FSU countries. The RHS estimates there are 1.5 abortions for every birth each year. Abortions constitute an important source of income for Ob/Gyns, and possibly midwives, and this may create resistance to promoting family planning. Although most women report knowing some family planning methods, only about 12 percent use modern methods, the lowest in the E&E region (55% use some family planning method). There is a high rate of unwanted pregnancies, with 57 percent of women reporting their last pregnancy as unintended. The total fertility rate is 2.1, with the population expected to stabilize at 9.5 million in 2025.

Approximately 66% of pregnant women attend antenatal clinics, but this level appears to be declining. According to the RHS, prenatal care is sub-standard, with 81% of women having received inadequate prenatal care in the five years prior the survey (Kotelchuk index). Official data indicate that 84% of deliveries are conducted by a skilled provider. However, the RHS also found that 26% of women delivered at home and in areas that the team visited, this proportion has reached as much as 50%, limiting access to skilled delivery attendants. Later studies demonstrate that 25% of women had no prenatal care visits, and the proportion of rural infants born at home increased from 37% in 1997 to 44% in 1999 (RHS, 2001). On the other hand, official MOH statistics state the proportion of women who delivered at home increased only from 2.3% to 8.6% of total labors “observed through MOH establishments” (MOH and SC 2001).

Health of Children

The reported infant mortality rate in 1993 was 28 per 1000 live births, and recent estimates are between 70 and 80 per 1000 (again, the disparity between official statistics and survey data). The infant mortality rate measured by the RHS is 80.8 per 1000 live births (with 38.1 neonatal, and 42.7 post-neonatal mortality, respectively), which is higher than in most of the former Soviet Union countries. The child-under-five mortality rate is 92.2 per 1000 live births. Official infant mortality statistics (25.8 per 1000 births, MOH 2001) are affected by such problems as non-registration of births of infants who die shortly after birth, as well as misclassification of neonatal deaths and stillbirths (RHS, 2001). The leading causes of death in children are acute lower respiratory infections (pneumonia), diarrhea, and neonatal conditions.

High levels of anemia (40% among women according to the RHS) and other micronutrient deficiencies also create complications (anemia among both women and children reportedly as high as 50% in certain regions). The rate of anemia among children aged 12- 59 months is 31.8%. The prevalence of iodine deficiency is high at 50 to 60%, and vitamin A deficiency was found in over 80% of children. The RHS also reports 13% for the overall prevalence of chronic malnutrition (stunting, or low height for age) and 2.4% for acute malnutrition (low weight for age, or wasting). The UNICEF MICS reports immunization coverage above the 85%. In 2004, the government of Azerbaijan assumed responsibility for procurement of all childhood vaccines except Hepatitis B and MMR². Immunization services appeared to be available at the health facilities even in the remote villages; however maintenance of the cold chain, timelines of vaccine administration and vaccine quality are often problematic.

Integrated management of childhood illness (IMCI) is new in Azerbaijan. The Mercy Corps child survival project and AHAP partners were able to initiate some activities in child survival, including implementation one full 11-day IMCI training course for health professionals in the southern region. Other partners, such as International Medical Corps (IMC) and Save the Children, have also utilized some IMCI modules in their respective projects, but with limited scope and uncertain sustainability. IMCI has been a key part of the health reform project under UNICEF/World Bank, although this component is still in its early stages. The MOH IMCI coordinator expressed an interest in expanding IMCI training on a wider scale. The community and household components of the wider applications of IMCI, which will incorporate key behaviors in health for caregivers and family members, has not yet begun. This too, might be an area within which USAID might also find support from the MOH, as the curricula has already been adapted to Azerbaijan and translated from Russian into Azeri. Several AHAP partners are well positioned to potentially take on the community-based aspects of IMCI to promote behavior change (e.g. 16 key family behaviors).

Infectious Diseases

With an estimated 1,400 HIV+ cases (based on UNAIDS projections), HIV/AIDS has not yet made a deep impact upon the population of Azerbaijan. The official number of HIV/AIDS cases reported is ~700, with almost one-half attributed to injecting drug use. Sexually transmitted diseases, such as syphilis, have also increased over the past decade. Low levels of knowledge about sexually transmitted infections (STIs) and HIV/AIDS, stigma, discrimination and denial by government officials, limited testing facilities, as well as an increase in commercial sex workers, drug trafficking, and mobility of young men to seek jobs are factors that may further aggravate the situation. Many medical professionals perceive HIV/AIDS as a 'Western' disease that is not a serious threat to Azerbaijan. The introduction of HIV in Azerbaijan is often linked to migratory workers who travel to Russia, and to foreigners.

There are now twelve HIV/AIDS regional testing centers throughout the country. However testing procedures do not seem to allow for anonymity and confidentiality, and the high-risk population groups are being neglected. Testing is still done by blood/lab analysis, but use of rapid, modern, and confidential means is not anticipated. A recent successful MOH application to the Global Fund for AIDS, Tuberculosis and Malaria (\$6.5 million) will allow the Ministry to establish voluntary counseling and testing sites (VCT) and conduct other activities, starting in 2005 through initial use of existing 27 UNFPA supported RH/FP centers, as well as expected new facilities. Universal

² Measles, Mumps, Rubella (MMR)

testing, counseling, and education are planned, including testing of pregnant women. Prevention of mother to child transmission (PMTCT) activities are also being planned, but potential treatment regimens for HIV+ mothers have not been clarified.

Azerbaijan has one of the highest tuberculosis rates in the WHO European region, with an annual estimated incidence of 74 cases per 100,000 population (WHO, 2004). With this increasing TB incidence, the MOH has received funding from the German Development Agency (GTZ), which has supported the GOAZ's national program of directly observed treatment – short course (DOTS). GTZ funding has increased public access to first-line TB drugs, improved lab equipment, provided training, and some rehabilitation of TB dispensaries (in tandem with the Japanese Development Agency). However, the assessment team was able to identify a number of gaps within the TB strategy and services that might benefit from further inputs. Although the DOTS strategy is used, in principle, including free access to TB treatment drugs, consumption of daily drug doses are not observed beyond the central clinics. Nor is it likely the contacts of TB patients are tested for infection. As TB drugs are only dispensed by TB specialist who are located in cities and rayon centers, TB patients residing in rural areas have less access to drugs and support that would ensure patient completion of the 6 month drug regimen. TB patients outside of urban areas where TB facilities are located are more likely to go undiagnosed, or if started on drug treatment, are likely to not return for the full course of treatment. Currently, only TB doctors are authorized to dispense TB drugs and to provide screening/testing, although rural FAPs and DACs could be effectively utilized in the DOTS effort with training, outreach, TB education, and contact follow up.

According to WHO, 80 percent of Azerbaijan is considered a malaria-endemic zone. However, comprehensive control efforts limited the incidence in 2002 to 506 cases with almost no mortality.

Non-Communicable and Chronic Diseases

The leading causes of morbidity in adults in Azerbaijan are cardiovascular disease, diabetes, injuries and cancers. A portion of the chronic disease burden is related to sedentary life styles, obesity, and cigarette and alcohol consumption. Among men, the incidence of cancer is highest for tracheal, bronchial, lung, and stomach cancers. In women, the incidence is highest for breast, cervical, and uterine cancers. Less than 30% of women of childbearing age (RHS) have ever heard about breast self examination techniques, and only 10% have ever done self-examination. Furthermore, only 1% of sexually experienced women had received a cervical cancer screening (Pap test) within the past three years. According to the WHO 2003 World Development Report, the life expectancy is 65.8 years, 63 for males and 68.6 for females. However, the nearly six year lower life expectancy for males indicates serious issues related to men's lifestyles, their burden of chronic disease, and the quality of their health care.

Reproductive health and Family Planning

Reproductive health services have improved somewhat over the past decade, largely due to the efforts of UNFPA and AHAP partners through the provision of training and supplies and establishment of FP centers. However, abortion remains the principle method of controlling fertility, with a total induced abortion rate of 3.2³, the second highest in the world among the countries for which RHS data is available. The RH Survey estimates 1.5 abortions for every birth

³ Number of abortions per woman per lifetime

annually. Among married Azeri women, 57 % of women interviewed stated that their last pregnancy was unintended (RHS 2001), and three fourths of sexually active women in one sample survey verbally reported at least one lifetime induced abortion (Relief International, 2001).

While the contraceptive prevalence rate (CPR) for all methods of contraception, including natural and traditional methods, has risen considerably over the past decade from 32% to 55%, the total fertility rate has decreased steadily, from 5.5 in 1960 to below replacement level now (2.1). Use of modern methods of contraception is the lowest (12%) among former Soviet republics with survey data. However, most women reported knowing some FP methods. Nearly half of the 12% of modern method users utilize an IUD⁴ (RHS, 2001). Contraceptive use is considerably higher among urban women than rural women. Relatively easy access to abortion has, and continues to play, a large role in reproductive behaviors and outcomes. Two-thirds of women reported symptoms suggestive of sexually transmitted infections (STI). Improved access to modern forms of contraception, provided in tandem with simple and creative media and education at all levels will decrease this predominant use of abortion. Easy access to low-cost abortion, in tandem with provider incentives, contributes to the low demand and use of modern contraception.

The ACQUIRE Project: A newly signed, \$8 million, five-year agreement with Engender Health will support a variety of reproductive health and family planning (RH/FP) activities, in cooperation with the GOAZ. This program will build upon important early steps taken through AHAP consortium partners and UNFPA, in reproductive health, through a wide array of activities including the introduction of training in post-abortion care and counseling for GOAZ health professionals. This RH/FP program aims to reduce abortion rates by increasing information, and improving access and use of affordable, high quality, and varied modern contraceptive methods, while also providing support to both community and health professionals. USAID will utilize this initiative to broaden the reproductive health dialogue with the MOH, and include other NGO partners, communities, and new institutions, such as the MOH National Reproductive Health Office. In addition, ACQUIRE will examine options for expanding availability of RH/FP information and services through the private sector, including general pharmacists, policy makers, and medical leaders through education in contraceptive technology and security, as well as social marketing. It will support RH/FP curriculum development and general public education, as well as community-based activities using cost-recovery mechanisms. With the Mission's RH/FP project implemented by ACQUIRE now underway, reproductive health, and family planning in particular, will be given focused attention. Program details will be refined following the baseline assessment.

UNFPA has supported the establishment of 27 GOAZ district level RH/FP centers to improve women's health and provide family planning. UNFPA also supports family life education in secondary schools, and selected maternal health activities. These RH/FP centers are of high quality – usually well stocked with contraceptives (condoms, oral contraceptives, IUDs, and Depo Provera). The GOAZ staff have been given training, supplies and equipment. These centers conduct education and FP counseling services, but also provide first trimester abortions (vacuum aspiration, called “mini-abortion”, conducted up to the 8th week of gestation). As USAID does not support any activities towards promotion of abortion, USAID support will provide education and training on use of modern methods of contraception, and application of post-abortion counseling as a means to prevent unwanted pregnancy. The RH/FP centers are providing a much needed service,

⁴ IUD – Intra-Uterine Device

and client response has been strong; however, it is unclear as to whether UNFPA will continue its programs in Azerbaijan, and the team was unable to meet with any representative from UNFPA.

Quality of Care and Medical Education

Capacity building for health care professionals, community leaders, peer educators and many others has already been undertaken by USAID partners in a wide array of subjects, including FP/RH, safe motherhood, HIV/AIDS, healthy living, CDD and ARI in infants. However, application of this training locally is still limited. Although equipment and facility renovation inputs have been provided in a variety of health delivery sites, many providers who have been trained return to a work environment with little support to develop practical skills; nor has there been sufficient on site monitoring and supervision to ensure basic skills have been incorporated into daily work routines. Follow on training is essential for the first groups of master trainers (AHAP project), as well as for additional staff in regions not yet covered. Further, key stakeholders at many levels have not yet had opportunities to participate in training or learn key messages needed to foster long term, concrete results. Specific training in patient counseling, management, and primary health care is also needed.

Pre-service education and training for physicians includes six years of medical education followed by one year of residency. The Ministry of Health is considering introduction of a 12-year education process for physicians that is similar to the Western model. The ratio of physicians per 1000 population is higher than in the countries of the European region. The WHO Regional Office for Europe reports 3.59 active physicians/1000 population, 0.26 active dentists/1000 population, and 0.26 active pharmacists/1000 population in 2001. Mid-level medical personnel (nurses, midwives and feldshers) go through a two year pre-service training in the nursing schools located in Baku, Sumgait, Ganja, Sheki, Lenkoran, Nahichevan and Mingechevir. According to the WHO Regional Office for Europe, there was 1/1000 population in 2002, which represents a slight decline over the past twenty years.⁵

In-Service Education: Originally, continuing medical education (CME) for health providers was conducted in the Soviet Union at the post-graduate school for physicians and nurses. Supporting in-service medical education for physicians and mid-level health professionals represents one of the major challenges that the health system is facing in the post-Soviet era due to scarce resources available for refresher training. Teaching curricula for medical and nursing schools have not been updated since the end of the Soviet Union. There is clearly a need for systematic and regular training of all levels of health professionals and health managers that will advance their familiarity with latest treatment protocols and approaches, health management, and health information systems.

Family Medicine: Training in Family Medicine is currently provided through a three month course at the Post-Graduate Training Institute, but this has not yet undergone peer review and may require revision. The Department of Family Medicine was created from the former Department of Polyclinics (within the undergraduate medical education system). The MOH has recently approved this Family Medicine curriculum. In addition, a number of doctors were trained using the Family Medicine curriculum at the pilot sites of the WB/UNICEF project. However, the organizational and policy structure that will support practicing family medicine are not yet in place.

⁵ Health Care in Transition, Azerbaijan 2004

Health Care Financing

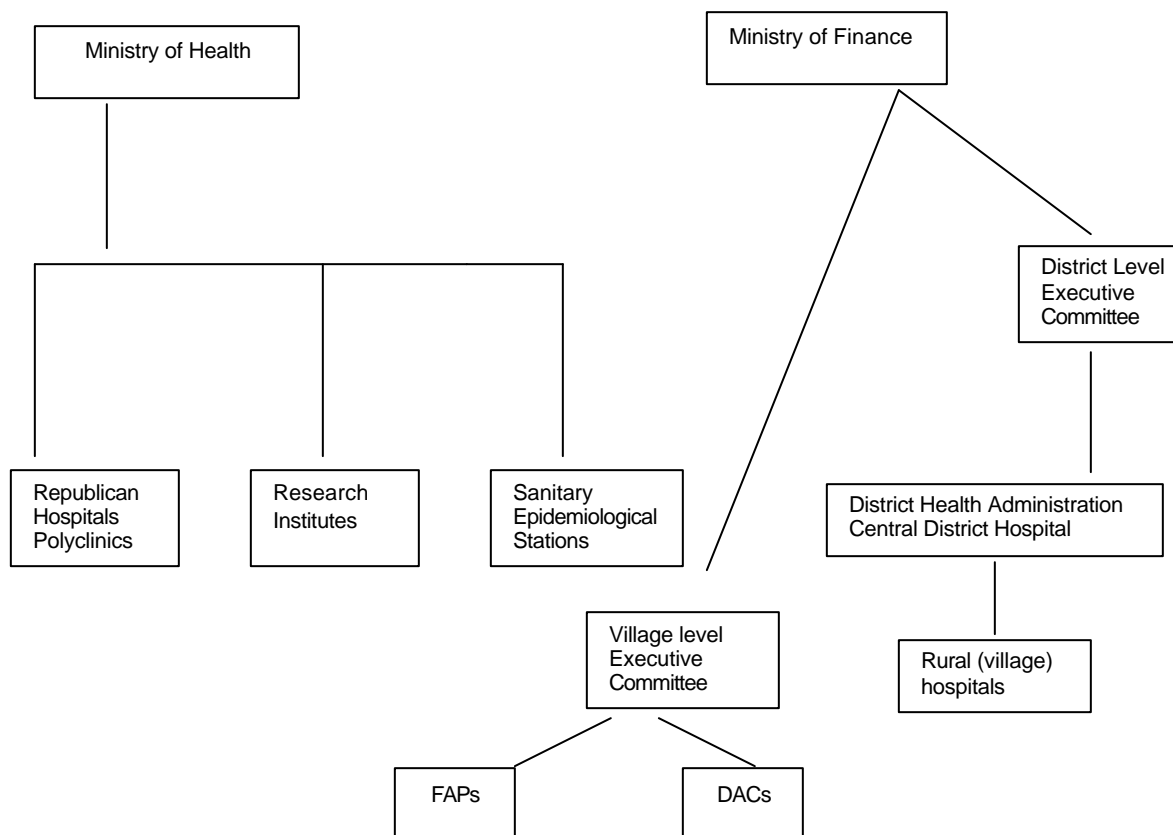
GOAZ budgets for the health sector have declined sharply since independence, with only 0.9% of GDP currently allocated for health as opposed to over 5% of GDP in the years just before independence. This is clearly one of the major reasons for the decline in coverage and quality of health services. Following a recent GOAZ policy change, responsibility for health budget disbursements was also split between the Ministry of Health and the Ministry of Finance. As outlined in Figure 2, the MOH disburses the budgets for the national (republican) and district hospitals, research institutes and Sanitary Epidemiological Stations (SES). The Ministry of Finance disburses health funds directly to city and district Executive Committees for all city/district level facilities and services except for the hospitals; the District Executive Committees, in turn, disburse funds to the local village Executive Committees who manage the financing of peripheral village health staff and services (the DACs and FAPs). This divided responsibility for health budget management often leads to a lack of coordination between the Executive Committees and the health authorities.

Azerbaijan has laws that provide for privatization of health care services, yet the government is still the predominate provider (only 2% of all health care facilities are private). Private health care facilities have been established primarily to provide services to employees of the oil companies. Laws also exist that create opportunities for various types of insurance, yet mandatory health insurance does not exist thus far. Voluntary health insurance is very costly and is used by only 0.1% of the population. Some INGOs have established community-based health insurance schemes or revolving drug funds in selected communities. However, there do not appear to be mechanisms to institutionalize or to sustain these beyond the lifetime of the INGO projects.

Similar to conditions under the Soviet system, health budgets are still generally dominated by hospital financing, with primary health care continuing to be a low budget priority. During site visits the team found DACs and FAPs generally lacking supplies and emergency medications, whereas hospitals and polyclinics were better off. Based on team observations, health care facilities supported by INGO inputs were improved; they often had been refurbished and stocked with some new equipment and supplies. The FP/RH Centers in the districts supported by UNFPA were either new or recently renovated buildings, had new equipment, and were better stocked with supplies and contraceptives.

The World Bank Project Appraisal Document for a Health Reform Project in Azerbaijan (2001) reported that “A new law on ‘Health Protection of the Population’ was passed in 1997. In 1998, a Health Reform Commission was established by Presidential Decree to develop a reform strategy, and in 1999, a document entitled ‘General Concept of Health Care Reorientation; was produced. Some of the characteristics envisioned for the new system are planned to be: (i) the rational use of the health delivery network, funding mechanisms, staff and other resources; (ii) the establishment of a new legal base for the system; (iii) primary care as a priority; (iv) reform of the sanitary-epidemiological services; (v) transition to principles of insurance; (vi) the development of fee-for-service; (vii) reform of the pharmaceutical sector; (viii) privatization of public health services; (ix) the accreditation, certification and licensing of medical establishments, personnel, medicines and foodstuffs; (x) the reform of medical education; (xi) the reform of medical science; and (xii) the reform of the health information system.” However, most of the initiatives outlined in the Decree are still in early stages or have not begun, though they provide a broad framework for health reform.

Figure 2⁶: Budget Flow Managed by the MOH and MOF



Cooperation with MOH

Several of the initial meetings of the team with key MOH officials were instructive about their view of cooperation and collaborative relationships, based on how they described their priorities and their experiences with other projects. Several of the MOH officials described their concerns with some aspects of the World Bank Health Reform Project, implemented in partnership with UNICEF. Later, the team also heard many positive insights from district health leaders during the field visits regarding this WB project, particularly regarding important renovations, training, and links to the communities. AHAP and AIHA have both had success working with the MOH at the district and community level.

A Health Advisory Group has been recently established by the USAID Mission in Baku as part of early steps to broaden dialogue and cooperation with the MOH. The initial advisory meeting was met with enthusiasm and will be a regular forum for discussion, dissemination, and policy reform. It could also be used to present the emerging parts of the new health program, introduce the RH/FP component, and discuss plans for the next family health/PHC/health reform component. Similarly, as the components of USAID's program move into implementation and focus districts are

⁶ Information from Field Visits

identified, the Mission might organize joint meetings of district health leaders to participate in the planning process and lay the groundwork for implementation.

Within the MOH, the Department of International Relations is responsible for overseeing INGO, NGO, UN, and other donor agency activities in Azerbaijan. The department staff look forward to further collaboration with the USAID Mission and building upon early program efforts in a more consultative fashion.

Further, the National Reproductive Health Office (NHRO), organized within the MOH, and developed with UNFPA support, brings promise for further collaboration and coordination in the arena of reproductive and maternal health. There exists a RH/FP Technical Working Group – which is an amalgam of RH/FP professionals and stakeholders at the central level. This too, is in the early stages and would benefit from further recognition and participation.

In early December, 2004 National Conference on Health Reform was held, attended by high level Ministry officials and a broad array of stakeholders.

Also, within the ministry is another individual who has been designated as the IMCI Coordinator and has been tasked with coordinating advancements in IMCI introduction, still at an early stage. The Family Medicine coordinator has taken important early steps (with supports through the AIHA partnership) toward the promotion and development of FM education within the medical institution; continued dialogue and supports to her and her team in terms of policy reform are critical.

Health Promotion, Communications and Behavior Change

In the tradition of Soviet health care system, the MOH gives inadequate emphasis to educating the populace and clients both on health risks, appropriate behaviors to prevent illness and promote health, nor does it encourage or equip individuals, families and communities to take responsibility for its own health. The current approach is to encourage clients to seek care and leave all decisions to the health care provider. Moreover, there is no unit within the MOH that develops and manages health communications, education and promotion, leaving the various technical units to utilize outdated pre-independence materials. UNICEF and INGOS have supported production of posters and other updated educational materials particularly focused on maternal and child health, which were evident in many facilities the team visited.

Accurate, client-oriented information and communication is basic to promotion of healthy behaviors, as well as being an important element in building community capability and initiative. In the ACQUIRE proposal for implementing the new reproductive health/family planning program component of the Mission's health strategy, one of the key partners, Meridian International, will support development of creative communications, advertising and social marketing to promote and strengthen knowledge and demand for reproductive health/family planning and will work on developing social and commercial marketing approaches to increase availability of information and contraceptive supplies. Likewise, ACQUIRE will hire a Behavior Change Communications (BCC) Specialist to work intensively with the community education/promotion component.

Follow-on health surveys

A second Reproductive Health Survey (RHS) has been proposed to follow on from the one done in 2001. The results of the 2001 survey have been a rich, valuable source of data for assessing the demographic and health situation in an environment where available vital and service statistics may be incomplete or not represent accurately the current country health profile. Coupled with the child health data generated by the 2000 UNICEF-sponsored Multiple Indicators Cluster Survey (MICS), there is a substantially detailed epidemiological and health behavior profile that amplifies the statistics provided by the MOH. However, from the team's discussions and review of limited data provided by district officials, it appears that some health indicators have been changing in the past four or five years. There have also been a variety of health intervention programs whose health impact needs to be assessed. And, as USAID begins a new five-year health strategy, a new survey would provide a set of baseline benchmarks against which future progress can be measured.

Both the RH/FP and Family Health/PHC/Health Reform components of the new USAID program will become operational before the end of 2005. It would be advisable to begin preparation for the follow-on survey early in 2005 and initiate field data gathering in early 2006. This would probably make tabular data available by mid-2006 and a full report by the end of the year.

The assessment team also learned that UNICEF is planning to implement a follow-up MICS in June 2005 to coincide with the startup of their new five-year Country Plan. UNICEF staff invited USAID to participate in the planning of their survey, and USAID likewise invited UNICEF to participate in the development of Mission planning of the follow-on health survey scheduled for the early 2006. Both USAID and UNICEF agree that broad participation and support for the surveys—including the GOAZ—is important to build complementarity and avoid duplication, and, more critical, to ensure creation of a sense of ownership in the MOH, essential in creating an environment of mutual trust and credibility to foster collaboration and change.

USAID, Other Donors, and Linkages

The World Bank Health Reform Project (\$5 million, ending 2005), implemented by UNICEF in cooperation with the MOH, has attempted to reform PHC services in five pilot districts. Training and other activities have been implemented over a period of four years. This program was designed to lay the groundwork for larger scale health care reforms in Azerbaijan. The World Bank is now conducting a pharmaceutical study meant to expedite an essential drug list and a household expenditure survey which will provide important data for future health reform initiatives with both the MOH and the MOF.

The UNICEF-supported program aims to reduce infant, child, and maternal mortality rates by supporting immunization efforts, health worker training using the integrated management of childhood illness approach (IMCI), safe motherhood, breastfeeding promotion, and other standard UNICEF health initiatives for women and children. WHO, in collaboration with the World Bank, is working with the MOH to develop a new Health Strategy Paper. UNICEF, under new, energetic leadership, has drafted its new Five Year Country Plan scheduled to begin in 2005. This plan will likely focus on: child health and nutrition, rights of the child, policy reform, and community development.

The Azerbaijan International Oil Consortium (AIOC) is a consortium of 11 companies developing offshore oilfields in the Azerbaijan section of the Caspian Sea. The Baku – Tbilisi – Ceyhan (BTC) Community Investment Program (CIP) under the auspices of AIOC implements community

mobilization and health programs along the BTC pipeline route on the model developed by USAID-funded programs. These programs are implemented by several INGOs, including International Medical Corps (IMC), Save the Children, and the International Rescue Committee (IRC). AHAP partners indicated that these companies have expressed interest in supporting health activities.

Other donors include the Asian Development Bank, which has a joint project with for salt iodization and flour fortification, and as mentioned previously, the German Cooperation Agency (GTZ) provides targeted support for TB DOTS programs throughout the country. The Japanese International Cooperation Agency (JICA) has also been supporting rehabilitation of several centers/hospitals throughout AZ. Also, the Ministry of Health is expecting an award of \$6.5 million from the Global Fund for HIV/AIDS, and a further application to the Global Fund will be submitted by the MOH next year to support malaria and TB.

OPPORTUNITIES FOR USAID IN THE HEALTH SECTOR

The following section outlines potential avenues that USAID might consider for working in the health sector in Azerbaijan. These recommendations are listed according to the results framework that is part of the Missions current health strategy.

Strategic Objective 3.4 – *Increase Use of Social and Health Services and Changed Behavior* **Intermediate Result 3.4.2- *Improved Primary Health Care Services***

Three sub-IRs are critical to the success of IR 3.4.2:

Sub-IR 3.4.2.1: Increased Availability of Priority PHC Services, Especially Child and Reproductive Health.

The suggestions proposed by the team focus primarily on non-Reproductive Health/Family Planning activities—except where a new need may exist—as the Engender/ACQUIRE program currently starting up comprehensively addresses most aspects of RH/FP that the Mission has defined. Consequently, the team’s suggestions focus on child and maternal health (some overlap with reproductive health), infectious diseases, and the key area of health reform. The impact of this result is directed at providing integrated primary health care services to population.

Recommendations: 3.4.2.1 – Increased Availability of Priority Primary Health Care Service

- Work at the policy level to better define and strengthen PHC in Azerbaijan. This definition should address integrated outpatient services that can meet the basic health care needs of all family members at the community level. This most likely would include strengthening the DACs and FAPs in the rural areas, as well as integrating services currently located in the polyclinics in the central districts, towns and cities.
- Strengthen capacity at national and district level decision makers to better utilize data for planning, decision making, and monitoring results.
- Dialogue with both MOF and MOH to support and encourage policy changes that allow for more rational budget allocations for health, and especially for primary health care.

- Undergraduate and Post-graduate training in family medicine and/or integrated PHC need to be strengthened and supported. Although there is a three-month post graduate course in family medicine, the curriculum needs to be reviewed and upgraded. Additionally, Family Medicine, as a specialty, should be recognized by the MOH with development of a curriculum for the undergraduate level.
- USAID's health program team should create concrete programmatic linkages to specific MOH counterparts, including National Reproductive Health Office (NRHO), the National Coordinator for Family Medicine, the IMCI National Coordinator, and the MOH International Relations Department.
- USAID organized the MOH Advisory Group, designed to open dialogue on key topics of mutual interest. It is important that this process continue, as it permits USAID to hear the priorities, concerns and directions of many of the departments within the MOH. It also creates a forum for idea exchange between USAID and many of the leaders within the MOH.
- Currently family planning services can only be provided by a gynecologist, who is normally located in district centers and cities, making it difficult for someone living in rural areas to get a prescription for contraceptives. There is a need for a policy change that would make family planning services available in the rural communities an issue as part of the current ACQUIRE scope of work.
- Under DOTS, TB drugs can only be dispensed by TB specialists, who are only located in district centers and cities, making it almost impossible for the drug therapy to be directly observed. There is a need for a change in policy that would allow the dispensing of drugs following initial treatment and prescription to be done by health care providers who work/reside in the same community as the TB patient.
- USAID should seek opportunities to enhance HIV service activities and prevention, targeting risk high populations, as possible, including PMTCT, such as VCT sites and other related supports.
- USAID's program should support expanding availability of priority health services by improving provider capacity, strengthening antenatal care, skilled delivery, introducing best practices such as active management of third stage labor (AMTSL), basic practices for care of and protection of the newborn, and in recognizing, treating, and referring the most common childhood killers, diarrhea and acute respiratory infections. The new, more effective ORS formulation, now promoted by WHO/UNICEF along with inexpensive zinc tablets for diarrhea, could be easily added to the health providers' technical update.

Sub-IR 3.4.2.2: People Better Informed About PHC Services, Healthy Lifestyles and Personal Responsibilities.

A range of awareness-raising approaches will be applied to obtain the results of this sub-IR, including use of the media, counseling, community activities and association development. Parents, families, and individuals need information to improve their health and the well-being of their families. USAID will bring about this key intermediate result by supporting an information program that will include potential clients, service providers, and stakeholders and ensuring that citizens are equipped to make responsible decisions that affect their health status.

Recommendations: 3.4.2.2 – People Better Informed about PHC Services, Healthy Lifestyles and Personal Responsibilities

- There is a need for a more national approach to health communication and promotion. Currently there is no one department within the MOH responsible for health promotion. There is a need to support the MOH to create a coordination mechanism responsible for health promotion/education. Following this, technical assistance and training on health promotion methods and programming needs to be provided.
- Community-based activities should support family participation in their own health care. This should include educating them on what services they should expect from PHC, as well as activities/messages on promotion of healthy lifestyles and prevention and early treatment of common illnesses.
- An education/communications/health promotion component would similarly be very important when the Mission develops plans for the content of the forthcoming health/PHC/reform component of its Five Year Strategy. This technical component should address several aspects of communications/health promotion linked to building awareness and achieving behavior change. It should include communications approaches directed at the family and community level, but also should look at the possibility of national or sub-national public education campaigns.
- The health communications/promotion component of the new health support program will need to be closely coordinated with the ACQUIRE communications component, to pool their technical expertise, and also with UNICEF, which has extensive experience and emphasis in this area. USAID should work collaboratively with national and regional governments to build understanding and develop communication strategies for campaigns on women's or children's health, HIV/AIDS, and other priority health problems. USAID should also seek the active participation of the MOH in planning communications approaches, and consider providing technical support and advocate for creation of a health education/promotion/behavior change unit in the ministry.

Sub-IR 3.4.2.3: Improved Quality of PHC Services, Especially Child and Reproductive Health.

Results will be achieved through a series of pragmatic, affordable approaches to enhancing quality of care. The focus will be on improving the delivery system for better patient care. Many key services for serious health issues in Azerbaijan are outdated, ineffective and ultimately unattractive to patients. If the quality of such services is improved, more people will seek formal treatment when ill.

Recommendations: 3.4.2.3 – Improved Quality of Primary Health Care Services

- Upgrade clinical skills of health care providers, especially related to primary health care issues, utilizing international standards and evidence-based protocols. This can also include retraining and/or cross-training PHC providers (doctors, feldshers, midwives and nurses) to offer basic services to all members of a family/community, including prenatal care, newborn care, family planning, immunizations, pediatric care, first aid, screening and referral, follow-up care & case management for chronic conditions (e.g., hypertension, diabetes, TB/DOTS), and patient education.

- Develop and strengthen the capacity for health services management. This would include using local data for local decision making, as well as training and technical assistance for management skills and supportive supervision to reinforce practical skills at the point of service delivery (competency based).
- With additional training the role of mid-level providers (nurses, midwives and fieldshers) should allow an expanded range of clinical services and patient education.
- Continued support for training to address critical maternal and child health issues. This can include the rollout of IMCI and similar case management strategies, with follow-up mechanisms to provide supportive supervision.
- Before beginning any effort aimed at improving the quality of care, there should be a complete inventory and review training curricula, clinical protocols and health promotion materials currently available in Azerbaijan.
- USAID training will foster a client-oriented approach.

Top Down Bottom Up Health Reform

The new strategy should reflect the transition to a more integrated primary health care program supported by top down, bottom up health reform. Based on the assessment team's review of documents, discussions with MOH officials, NGO partners and donor counterparts, visits to a selected number of field sites and meetings with community members, several major areas of importance have emerged:

- First, next steps must capitalize on the experiences and lessons learned from ongoing programs AHAP, WB/UNICEF health reform/PHC, UNFPA RH/FP, and others.
- Secondly, the importance of integrating key primary care services and coordinating closely the technical support programs for RH/FP and new components of child and maternal health within that PHC framework.
- There exists a need for a strong health reform technical support component in the USAID's new health project which works on a policy and program reform agenda at the MOH and coordinates the implementation of that agenda at the district and community level to reinforce the package of technical interventions to strengthen the content, quality and delivery of health services.
- The health program should begin in selected districts which have a demonstrated interest and effective implementation experience in some of the ongoing PHC, RH and health reform programs, building on the successful experiences to demonstrate the potential to the MOH leadership.
- Attention should also be given to selected poorer, underserved communities with unequal access to services, to also demonstrate the importance of maintaining equity in the program.
- Top Down, Bottom Up Reform: It seems clear that the proposed improvements and impact in the content and systems of delivering primary health care can only be achieved in a sustainable fashion with a wide range of significant changes in GOAZ policies, financial systems and allocation mechanisms, and other health reforms at the national level, as well as at the district and community levels. These issues concern not only the MOH, but often involve the critical role of the Ministry of Finance, as well as the President's office.

Critical top down reforms include:

- Increasing the proportion of the national budget allocated to health, especially in light of the increasing revenues from petroleum development.
- Rational allocation of health budgetary resources away from the current dysfunctional system based on the number of hospital beds to one based on population and health needs. This shift is particularly important for strengthening primary health care, as a substantial reduction of beds would free up resources to strengthen the role and upgrade the skills of key health providers in the peripheral facilities, which is critical to making more cost-effective services available closer to the families and more accessible to poorer clients.
- Modified definition of primary health care to emphasize integrated provision of basic services, expanded preventive services and health education/promotion, and upgrading technical and managerial skills of the midwives, feldshers and doctors who staff the peripheral village hospitals/clinics, feldsher and midwifery posts (DACs and FAPs) who are the closest (and often the only) source of care in the community.
- To further reinforce the integration and improvement of primary health care will require improvement and institutionalization of the curriculum and training for family medicine physicians, building on the initiatives that have begun in a limited way.
- Changes in technical/programmatic policies relating to who is authorized to provide services and drugs, such oral pills restricted to prescription only by ob/gyns, TB drugs only by physicians; and the general limitation of many services to hospitals and physicians that could be more efficiently shared and decentralized to non-medical providers, particularly at the peripheral health facilities outside of district or town areas.

Issues/actions critical to bottom-up reform are:

- Improving the technical capacity of health providers at the community level, bringing the full range of basic primary health care services, including prevention and promotion, close to the families and communities. The MOH needs to give more emphasis to the declining access to care for both urban and rural poor and people in remote areas.
- The Mission should draw on the wide range of successful experiences of the INGOs and other donors in building community involvement, knowledge and organization to better understand and take more responsibility for their own health needs, but also in stimulating advocacy and action to make health services more responsive and accessible. Look at the feasibility of more sustainable community health funds.
- Where possible, involve experienced NGOs in the process of identifying successful models of community involvement and actions that have potential for long term sustainability. The Mission should consider including NGO partners in its plan for implementing the Primary Health Care/Health Reform project.

Because of the critical importance of a wide range of policy reforms, health system changes, and financing reforms in the achievement and sustainability of the IRs, and given the Mission's expanding dialogue with the GOAZ, the team suggests that the Mission consider an **additional cross-cutting IR**:

Increased achievement of policy reform milestones that support and sustain health care and health status improvements.

Admittedly, policy reform and action is the most challenging area for the Mission strategy, and substantial health progress can be achieved even as the pace of reform is slow. But a specific IR gives prominent recognition to reform as a critical element in the strategy in the coming five years. Specific indicators and activities that are concrete and realistic need to be vetted in the Mission, but some areas are discussed in the previous section on “Top-down, bottom up Reform”.

Most of the national level policy issues are extremely challenging, but there is strong interest and commitment among key donors such as the World Bank, UNICEF, as well as the INGOs to continue lobbying and supporting technical efforts and dialogue that can facilitate health reform, in face of considerable resistance. There has clearly been some progress on several of the policy fronts. A number of health reform initiatives are under way, including, in particular, the World Bank/UNICEF health reform project, which ends in 2005, but which may be continued under follow-on projects, and may present USAID opportunities to collaborate and draw on its experience in other countries of the region. Other potential influences for reform were noted to the team, including the GOAZ desire to qualify for Millennium Challenge funding and the pressure to meet the Millennium Development Goals in health.

ANNEX 1: Meetings Conducted by the Assessment Team

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Gulshan Akhundova, Team Leader, IRD
Shamil Kalyayev, Country Representative, IRD
Sue Leonard, Program Director, Mercy Corps
Saida Ismaylova, Team Leader RH/FP, Save the Children
Mehriban Mammadova, Senior Training Coordinator, Save the Children
Hanaa Singer, UNICEF Representative
Lilia Turcan, UNICEF Project Director
Gillian Wilcox, UNICEF, Program Coordinator
Shafag Rahimova, UNICEF, EPI
Farman Abdullayev, WHO Liaison Officer Azerbaijan
Jeyhoun Mamedov, Program Coordinator AIHA
Nata Avaliani, Regional Director AIHA
Antonio Lim, Operations Officer, the World Bank
Elvira Anadolu, Operations Officer, the World Bank
Azer Ahmedoglu Maharramov, Director, Health Reform Project (MOH/WB)
Alexander Umnyashkin, International Relations Head, Ministry of Health
Oktay Akhundov, Director, Dept. of HIS, Ministry of Health
Qalib Aliyev, National AIDS Coordinator, Ministry of Health
Hasrat Huseynov, Chief of Ganja Health Department (MOH)
Issaat Shamkholova, Director/Coordinator; Nat'l RH/FP Center Institute; NHRO Director
Svetlana Mamedova, National TB Coordinator, Institute of Pulmonology
Asif Seyfullayev, IMCI National Coordinator
Cornelia Henning, TB Prevention project manager, GTZ
Ogtay Gezalov, TB Project Coordinator, GTZ
Enis Baris, Senior Public Health Specialist, Human Development Unit, ECA, World Bank
Paula Panopoolou, World Bank
Mahir Gasimov, Chief Doctor, Sheki (MOH)
Rudmilla Ayluyuva, UNFPA/FP Center Gazakh
Ahmed Gurbanov, Head Doctor, Gazakh
Nurraddin Ahmedov, Head Doctor, Shamkir
A.I. Kazimov, Director, Center for Hygiene & Epidemiology
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Valerie Ibaan, USAID, Social Sector Advisor

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Nadir Jafarov, Executive Director, Shafali Allar LNGO
Tahir Mikayilov, District Head Doctor, Imishli District
Adil Mustafayev, Deputy Head Doctor, Imishli District
Ahad Yusifli, Director of Imishli District Center of Hygiene and Epidemiology
Dr. Baram Shukurov, Head Doctor of the clinic, Imishli District
Fehrur Sultanov, District Head Doctor, Yardimli District
Mirabulfaz mammadli, District Chief Pediatrician, Yardimli District
Leyla Mammadova, Gynecologist, Yardimli District
Isakhan Alibeili, Community Health Educator, Yardimli District
Aligulu Shiriniv, Head Doctor of DAC, Yardimli District
Vakil Sharbatov, Head Doctor of Village hospital, Yardimli District
Gabil Bagishov, Chairman of CHC, Yardimli District
Saadatkhan Aliyev, District Head Doctor, Jalilabad District
Valeh Mammadov, Deputy District Head Doctor, Jalilabad District
Shafiga Aliyeva, Director Family Planning Center (FPC), Jalilabad District
Ibeahim Jafarov, District Head Doctor, Salyan District
Ahmad Rzaev, Deputy District Head Doctor, Salyan District
Aflatun Tagiyev, Head Doctor of DAC, Salyan District
Farhad Sahbanov, Head of Health clinic, Salyan District
Bahram Shahverdiyev, District Head Doctor, Khachmaz District
Ramiz Sirajov, Deputy District Head Doctor, Khachmaz District
Kamal Agayev, Head Doctor of TB dispensary, Khachmaz District
Zakir Ismaylov, UNICEF Clinical facilitator, Khachmaz District
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